

Eligibility Response

Response Generated:

Your Request

Payer	CIGNA
Provider ID (NPI)	1487113239 - HomeCentris Home Health
Service Dates	1/16/2026
Last Name	ROUSE
First Name	JANET
Middle Name/Init	D
Member ID	20004363
DOB	8/11/1955
EVC Number	838756170

Patient Demographics

Address	327 ALLENDALE ST, BALTIMORE, MD 21229-2909
Gender	F

Eligibility State:

☒ Active Coverage

☐ Display on Dashboard

☒ Currently Unreviewed

Owner:

Me (Sta. Rita, Jasmin)

Follow-up Status:

☐ Financial Counseling/Self Pay

☐ Front Desk

☐ POS Collection

Follow-up Date:

mm/dd/yyyy

Add Request to Batch

Choose a Batch

Update Request

Service Coverage Overview

0 User Note(s)

Eligibility Summary: Active Coverage

Plan Name:	HealthSpring TotalCare Plus (HMO D-SNP)
Plan Start Date:	1/1/2024
Plan End Date:	
Sub. Group Number:	H2108_041_000 - HealthSpring TotalCare Plus (HMO D-SNP)

Primary Care Provider

PCP Name:	MidAtlantic MA HMO Non Alliance PCPs
Service Type:	Medical Care
PCP Name:	RICHARD WALSH
Address:	4660 WILKENS AVE STE 100, BALTIMORE, MD 21229
NPI:	1427010958
Telephone:	(410) 247-0782
Service Type:	Medical Care

Service Types

[Go To Top](#)

Displaying 48 of 48 sections

[Edit Display](#) [Show All](#) [Hide All](#)

Health Benefit Plan Coverage (30)

[Hide](#)

Insurance Type:	Health Maintenance Organization (HMO)
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Deductible:	\$283.00 (In Plan Network) Message: \$283 MEDICARE-DEFINED PART B DEDUCTIBLE Message: Part A/B deductible
Out of Pocket (Stop Loss):	\$9,250.00 / Calendar Year (In Plan Network) Message: \$9,250 Message: Maximum Out-of-Pocket Cost (MOOP) \$9,250.00 / Remaining (In Plan Network) Message: TOTAL MOOP REMAINING AMOUNT IS \$9250.00 Message: Out-Of-Pocket (MOOP) remaining amount

Acupuncture (64)

[Hide](#)

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance;Medicare-covered Acupuncture - 20 Message: Limited to 12 visits per year in 90 days by a licensed provider for chronic low back pain. Additional 8 sessions may be covered. No more than 20 acupuncture treatments allowed per year Message: Other Health Care Professional

Ambulatory Service Center Facility (13)

[Hide](#)

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other Ambulatory Surgical Center (ASC) services. Message: Ambulatory Surgical Center (ASC) Services

Anesthesia (7)

[Hide](#)

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual

Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Physician Specialist
Audiology Exam (71) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: Hearing Exams (Medicare-covered)
Co-Payment:	\$0.00 (In Plan Network) Message: \$0 copay for 1 visit every Year Message: Multiple fittings are allowed with the original provider if necessary to ensure hearing aids are accurately fitted. To schedule an appointment, call 1-866-872-1001 Mon - Fri from 7 a.m. to 7 p.m. CST Message: Hearing Aid Evaluation/Fitting Message: To schedule an appointment, call Hearing Care Solutions, Mon - Fri at 866-872-1001 from 7 a.m. to 7 p.m. CST Message: Routine Hearing Exams
Cardiac (BL) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	\$0.00 (In Plan Network) Message: \$0 copay Message: Medicare-covered Preventive services
Cardiac Rehabilitation (BG) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: Cardiac Rehab Services Message: Pulmonary Rehab Services 20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Supervised Exercise Therapy (SET) for Symptomatic PAD Services
Chemotherapy (78) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	0% (In Plan Network) Authorization Required Message: 0 coinsurance is to reflect the lowest possible coinsurance for a Part B rebatable drug per CMS guidance, up to 20 coinsurance.

	Message: Other Medicare Part B Drugs Message: Medicare Part B Chemotherapy/Radiation Drugs 20% (In Plan Network) Message: 0 - 20 coinsurance up to \$35 Message: Medicare Part B Insulin Drugs
Chiropractic (33) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Chiropractic (Medicare-covered)
Dental Care (35) Hide	
Insurance Type:	Health Maintenance Organization (HMO)
Active Coverage:	Description: Dental HMO Eligibility Begin: 1/1/2024
Diagnostic Lab (5) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: After plan deductible, 20 coinsurance applies to genetic testing (except Cologuard and Molecular Pathology Interpretation). 0 coinsurance applies to all other diagnostic lab services. Message: Lab Services Message: 0 coinsurance for EKG. After plan deductible, 20 coinsurance for all other diagnostic procedures and tests. Message: Diagnostic Procedures/Tests
Diagnostic Medical (73) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 0 coinsurance for diagnostic mammography and ultrasounds. After plan deductible, 20 coinsurance for all other diagnostic and nuclear medicine radiological services. Message: Diagnostic Radiological Services Message: After plan deductible, 20 coinsurance applies to genetic testing (except Cologuard and Molecular Pathology Interpretation). 0 coinsurance applies to all other diagnostic lab services. Message: Lab Services Message: 0 coinsurance for EKG. After plan deductible, 20 coinsurance for all other diagnostic procedures and tests. Message: Diagnostic Procedures/Tests
Diagnostic X-Ray (4) Hide	

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: X-Ray Services 20% (In Plan Network) Authorization Required Message: 0 coinsurance for diagnostic mammography and ultrasounds. After plan deductible, 20 coinsurance for all other diagnostic and nuclear medicine radiological services. Message: Diagnostic Radiological Services
Dialysis (76) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Dialysis Services
Co-Payment:	\$0.00 (In Plan Network) Message: \$0 copay Message: Kidney Disease Education Services
Durable Medical Equipment Purchase (12) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: DME Message: Medical Supplies
Co-Payment:	\$1,800.00 (In Plan Network) Message: \$399 - \$1800 copay per device for 2 every Year Message: Hearing aid devices do not include assisted listening devices, amplifiers or disposable devices. To schedule an appointment, call Hearing Care Solutions Mon - Fri at 866-872-1001 from 7 a.m. to 7 p.m. CST Message: Hearing Aids \$399.00 (In Plan Network) Message: \$399 - \$1800 copay per device for 2 every Year Message: Hearing aid devices do not include assisted listening devices, amplifiers or disposable devices. To schedule an appointment, call Hearing Care Solutions Mon - Fri at 866-872-1001 from 7 a.m. to 7 p.m. CST Message: Hearing Aids
Durable Medical Equipment Rental (18) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required

Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message : 20 coinsurance Message : DME
Emergency Services (86) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	\$115.00 (In Plan Network) Message : \$115 copay Message : Copay is waived if admitted to the hospital within 24 hours Message : Emergency Services
Generic Prescription Drug (92) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	\$0.00 (In Plan Network) Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Mail Order Pharmacy Cost Share - Two Month Supply \$0.00 (In Plan Network) Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply \$20.00 (In Plan Network) Message: Initial Coverage - Tier 2 Generic Drugs.Standard Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Standard Mail Order Pharmacy Cost Share - Two Month Supply \$15.00 (In Plan Network) Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Retail Pharmacy Cost Share - Three Month Supply \$10.00 (In Plan Network) Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Standard Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Mail Order Pharmacy Cost Share - Two Month Supply

	\$5.00 (In Plan Network) Message: Initial Coverage - Tier 1 Preferred Generic Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply \$30.00 (In Plan Network) Message: Initial Coverage - Tier 2 Generic Drugs.Standard Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Standard Retail Pharmacy Cost Share - Three Month Supply
Hospital (47) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 2026 STANDARD MEDICARE Message: Our plan covers an unlimited number of days for a Medicare-covered hospital stay Message: Inpatient Hospital Acute
Co-Payment:	\$80.00 (In Plan Network) Authorization Required Message: \$80 copay Message: Partial Hospitalization Message: Intensive Outpatient Services
Hospital - Ambulatory Surgical (53) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other Ambulatory Surgical Center (ASC) services. Message: Ambulatory Surgical Center (ASC) Services
Hospital - Emergency Accident (51) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	\$115.00 (In Plan Network) Message: \$115 copay Message: Copay is waived if admitted to the hospital within 24 hours Message: Emergency Services
Hospital - Emergency Medical (52) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	\$115.00 (In Plan Network)

	Message: \$115 copay Message: Copay is waived if admitted to the hospital within 24 hours Message: Emergency Services
Hospital - Inpatient (48) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 2026 STANDARD MEDICARE Message: Our plan covers an unlimited number of days for a Medicare-covered hospital stay Message: Inpatient Hospital Acute
Hospital - Outpatient (50) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other outpatient services not provided in an Ambulatory Surgical Center. Message: Outpatient Hospital Services Message: 20 coinsurance Message: Observation Services
Co-Payment:	\$0.00 (In Plan Network) Message: \$0 copay Message: Outpatient Blood Services
Immunizations (80) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	0% (In Plan Network) Authorization Required Message: 0 coinsurance is to reflect the lowest possible coinsurance for a Part B rebatable drug per CMS guidance, up to 20 coinsurance. Message: Other Medicare Part B Drugs Message: Medicare Part B Chemotherapy/Radiation Drugs 20% (In Plan Network) Message: 0 - 20 coinsurance up to \$35 Message: Medicare Part B Insulin Drugs
Mail Order Prescription Drug (90) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	23% (In Plan Network)

	Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Mail Order Pharmacy Cost Share - Two Month Supply
	25% (In Plan Network) Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply
Medical Care (1) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Physician Specialist 20% (In Plan Network) Message: 20 coinsurance Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services Message: Primary Care Physician
Mental Health (MH) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Mental Health Specialty-Individual Message: Mental Health Specialty-Group Message: Behavioral Health Telehealth Services Message: Physician Specialist 20% (In Plan Network) Authorization Required Message: 2026 STANDARD MEDICARE

Co-Payment:	Message: In some instances, a readmission policy may apply in which the benefit will continue from original admission. Message: Inpatient Hospital Psychiatric \$0.00 (In Plan Network) Message: \$0 copay Message: Medicare-covered Preventive services
MRI/CAT Scan (62) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 0 coinsurance for diagnostic mammography and ultrasounds. After plan deductible, 20 coinsurance for all other diagnostic and nuclear medicine radiological services. Message: Diagnostic Radiological Services
Occupational Therapy (AD) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Occupational Therapy
Pharmacy (88) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	23% (In Plan Network) Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply 25% (In Plan Network) Message: Initial Coverage - Tier 5 Specialty Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.Standard Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Retail Pharmacy Cost Share - Three Month Supply

	Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Retail Pharmacy Cost Share - One Month Supply
Physical Medicine (AE) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: PT and SP
Podiatry (93) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Medicare Part B covers podiatry services?for medically necessary treatment of foot injuries, diseases, or other medical conditions affecting the foot, ankle, or lower leg. Message: Podiatry (Medicare-covered)
Co-Payment:	\$0.00 12 Visits / Calendar Year (In Plan Network) Message: \$0 copay per visit for 12 visits every Year Message: Routine Podiatry
Professional (Physician) Visit - Home (A3) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Physician Specialist 20% (In Plan Network) Message: 20 coinsurance Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services Message: Primary Care Physician
Co-Payment:	\$0.00 (In Plan Network) Authorization Required Message: \$0 copay Message: Home Health
Professional (Physician) Visit - Inpatient (99) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual

Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Physician Specialist 20% (In Plan Network) Message: 20 coinsurance Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services Message: Primary Care Physician
Professional (Physician) Visit - Office (98) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Physician Specialist 20% (In Plan Network) Message: 20 coinsurance Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services Message: Annual Physical Exam Message: Primary Care Physician
Professional (Physician) Visit - Outpatient (A0) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Physician Specialist 20% (In Plan Network) Message: 20 coinsurance Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services Message: Primary Care Physician
Prosthetic Device (75) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: Prosthetic Devices

Radiation Therapy (6)		Hide
Active Coverage:	(In Plan Network)	
Coverage Basis:	(In Plan Network) Authorization Required	
Coverage Level:	Individual	
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 0 coinsurance for diagnostic mammography and ultrasounds. After plan deductible, 20 coinsurance for all other diagnostic and nuclear medicine radiological services. Message: Diagnostic Radiological Services Message: 20 coinsurance Message: Therapeutic Radiological Services	
Routine Physical (81)		Hide
Active Coverage:	(In Plan Network)	
Coverage Level:	Individual	
Co-Payment:	\$0.00 (In Plan Network) Message: \$0 copay Message: Medicare-covered Preventive services	
Skilled Nursing Care (AG)		Hide
Active Coverage:	(In Plan Network)	
Coverage Basis:	(In Plan Network) Authorization Required	
Coverage Level:	Individual	
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 2026 STANDARD MEDICARE Message: In some instances, a readmission policy may apply in which the benefit will continue from original admission. Message: Skilled Nursing Facility (SNF)	
Smoking Cessation (67)		Hide
Active Coverage:	(In Plan Network)	
Coverage Level:	Individual	
Co-Payment:	\$0.00 (In Plan Network) Message: \$0 copay Message: Medicare-covered Preventive services	
Speech Therapy (AF)		Hide
Active Coverage:	(In Plan Network)	
Coverage Basis:	(In Plan Network) Authorization Required	
Coverage Level:	Individual	
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance	

	Message: PT and SP
Substance Abuse (AI) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Authorization Required Message: 20 coinsurance Message: OP Substance Abuse-Individual Message: Opioid Treatment Services Message: OP Substance Abuse-Group
Surgical (2) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services Message: Primary Care Physician 20% (In Plan Network) Authorization Required Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other Ambulatory Surgical Center (ASC) services. Message: Ambulatory Surgical Center (ASC) Services Message: 20 coinsurance Message: Physician Specialist Message: Observation Services Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other outpatient services not provided in an Ambulatory Surgical Center. Message: Outpatient Hospital Services
Surgical Assistance (8) Hide	
Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) Authorization Required
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services Message: Primary Care Physician 20% (In Plan Network) Authorization Required Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other Ambulatory Surgical Center (ASC) services. Message: Ambulatory Surgical Center (ASC) Services Message: 20 coinsurance

	Message: Physician Specialist Message: Observation Services Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other outpatient services not provided in an Ambulatory Surgical Center. Message: Outpatient Hospital Services
Urgent Care (UC) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	\$115.00 (In Plan Network) Message: \$115 copay Message: Copay is waived if admitted to the hospital within 24 hours. Copay waived if admitted to the hospital within 24 hours. Maximum coverage of \$50,000 per year Message: Worldwide Emergency/Urgent Coverage/Emergency Transportation \$40.00 (In Plan Network) Message: \$40 copay Message: Copay is waived if admitted to the hospital within 24 hours Message: Urgently Needed Services
Vision (Optometry) (AL) Hide	
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 0 coinsurance for Medicare-covered diabetic retinopathy screening. After plan deductible, 20 coinsurance for all other Medicare-covered vision services. Message: Eye Exams (Medicare-covered)
Co-Payment:	\$300.00 (In Plan Network) Message: \$300 combined allowance amount every year Message: The allowance may only be applied to one set of eyewear per year. Customers may choose an eyeglass frame/lenses/lens combination or contact lenses, but not both. Message: Max Coverage Amount for Routine Eye Wear Coverage (Supplemental) \$0.00 (In Plan Network) Message: \$0 copay Message: Upgrades (Supplemental) Message: \$0 copay for 1 eyeglass lenses every year Message: Eyeglass Lenses (Supplemental) Message: Limited to one pair of eyeglasses or contact lenses after each cataract surgery Message: Eye wear (Medicare-covered) Message: \$0 copay for 1 eyeglasses(Lenses and Frames) every year Message: Eyeglasses (Lenses and Frames) (Supplemental) Message: \$0 copay for Unlimited contact lenses Message: Routine Eye Wear Coverage \$0.00 (In Plan Network) Message: Eyeglasses Frames (Supplemental) Message: \$0 copay for 1 eyeglasses frames every year Message: Medicare-covered Glaucoma Screening \$0.00 1 Visits / Calendar Year (In Plan Network) Message: \$0 copay for 1 routine exam every Year.For questions about eye exams, call EyeMed at 1-888-886-1995 (TTY 711) Mon.- Fri. from 8 00 a.m. to 2 a.m. EST, Saturday, 8 a.m. to 11 p.m. EST, Sunday, 11 a.m. to 8 p.m. EST . You can also visit EyeMed.com/CignaMedicare to find a network vision provider in your area Message: Routine Eye Exams

